



Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ Date of Birth: _____

Please check all that apply:

Via Vascular Staff:

May leave detailed message on voicemail at home #: _____

May leave detailed message on cellular voicemail #: _____

May leave detailed message on voicemail at work #: _____

May leave information with spouse (name): _____

May leave information with other family member: _____

May fax a detailed message to #: _____

May leave detailed message at a different location: _____

May send detailed message by email to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record. It is my responsibility to notify my healthcare provider should I change one or more of the above phone/fax or email.

I also acknowledge that with the authorization of messages on voicemail that other people in my household may hear the personal health information left on the voicemail message.

Patient or legally authorized individual signature

Date